EXHIBIT A

Dimitri Teresh, Esq.
The Killian Firm, P.C.
Tindall Executive Suites
107 Tindall Road
Middletown, New Jersey 07748
dteresh@tkfpc.com
732-912-2100
Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

AA MEDICAL, P.C. ON BEHALF OF PATIENT BS *Plaintiff,* v. IRON WORKERS LOCAL 40, 361 7 417 HEALTH FUND, *Defendant.*	Civil Action No.: 2:22-CV-1249-ENV-LGD **RESPONSE TO DOCUMENT PRODUCTION REQUESTS**

TO: Thomas P. Keane, Esq.
COLLERAN, O'HARA & MILLS, L.L.P.
100 Crossways Park Drive West, Suite 200
Woodbury, New York 11797
Attorneys for Defendant Iron Workers Local 40, 361 7 417 Health Fund

Plaintiff, AA Medical, P.C., hereby objects and responds to the First Set of Document Production Requests served by Defendant Iron Workers Local 40, 361 7 417 Health Fund in accordance with the Federal Rules of Civil Procedure and the Local Rules of this Court.

Dated: June 6, 2024 **THE KILLIAN FIRM, P.C.**

By: /s Dimitri Teresh
Dimitri Teresh

RESPONSE TO DEFENDANT'S FIRST SET OF DOCUMENT REQUESTS

1. Copies of Patient BS' medical record including, but not limited to, all records related to the procedure performed on June 16, 2021.

RESPONSE: AA Medical will produce non-privileged documents responsive to this request.

2. Any and all documents and/or communications submitted to Health Fund in connection with the original invoice for the procedure performed on June 16, 2021.

RESPONSE: AA Medical will produce non-privileged documents responsive to this request.

3. A copy of the appeal sent to the Defendant on December 15, 2021, as alleged in Paragraph 28 of the Amended Complaint. Please identify the form in which the appeal was submitted to the Health Fund.

RESPONSE: AA Medical will produce non-privileged documents responsive to this request.

4. Any and all documents and/or communications submitted by AA Medical to the Health Fund when AA Medical submitted its appeal on December 15, 2021.

RESPONSE: AA Medical will produce non-privileged documents responsive to this request.

5. Please identify the date on which Plaintiff transmitted the medical literature referenced in Paragraphs 21, 22 and 23 of the Amended Complaint were submitted to the Health Fund. Please provide a copy of the studies referenced in Paragraphs 21, 22 and 23 of the Amended Complaint.

RESPONSE: The medical literature was not provided to defendant.

6. A copy of the assignment from Patient BS to AA Medical.

RESPONSE: AA Medical will produce non-privileged documents responsive to this request.

7. Copies of any and all communications between Plaintiff and the Health Fund regarding the events giving rise to this lawsuit.

RESPONSE: AA Medical will produce non-privileged documents responsive to this request.

INTAKE PAPERWORK for SIDOTE, BRIAN 04/16/1987 (37yo M) #21992

DocuSign Envelope ID: 1258E7BB-7635-4939-8ED8-242CCF932DF3

Name: Brian SIDOTE **DOB:** 04/16/1987

COMPLETE ORTHOPEDICS
www.cortho.org
631-981-2663

History of Present Illness

Height: 5'8 **Weight:** 205

Description of how the problem happened:
I have had knee problems in the past but it was never treated, wednesday I was playing kickball and my knee buckled

Location of Pain/Body Part:
- ☒ Left Knee
- ☐ Right
- ☐ Other

Quality of Pain
- ☐ Aching
- ☐ Burning
- ☐ Stabbing
- ☐ Throbbing
- ☒ Sharp
- ☐ Dull
- ☐ Occasional
- ☐ Frequent
- ☒ Constant
- ☒ Worsening
- ☐ Improving
- ☐ Not changing

Severity of Pain
- ☐ No Pain
- ☐ Mild
- ☐ Moderate
- ☒ Severe

Duration
- ☒ Date of Onset: 5/25/21

Timing
- ☐ Acute
- ☒ Chronic
- ☐ Nighttime
- ☐ Recurrent
- ☐ Occasional

Context
- ☐ Fall
- ☐ Lifting
- ☐ Twisting
- ☒ Sports Injury
- ☐ Work Injury
- ☐ Motor Vehicle Accident (MVA)
- ☐ Assault

Alleviating Factors
- ☒ Nothing helps
- ☐ Lying Down
- ☐ Position Change
- ☐ Heat
- ☐ Ice
- ☐ Rest
- ☐ Exercise / Stretching
- ☐ OTC Medication
- ☐ Narcotics

Aggravating Factors
- ☒ Standing
- ☒ Walking
- ☒ Lifting
- ☒ Twisting
- ☒ Pushing / Pulling
- ☐ Throwing
- ☒ Weight Bearing
- ☒ Exercise
- ☒ Upstairs
- ☒ Downstairs
- ☐ Nighttime
- ☐ Cold Weather

Associated Symptoms
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☒ Swelling
- ☐ Redness
- ☐ Warmth
- ☐ Catching / Locking
- ☐ Popping / Clicking
- ☐ Buckling
- ☐ Grinding
- ☐ Instability
- ☐ Radiation down leg
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Bladder/Bowel habits
- ☐ Tender to touch
- ☒ Pain with motion

Previous Surgery (for current issue)
- ☒ None
- ☐ Surgery Type & Date:

Prior Imaging
- ☐ None
- ☒ Xray
- ☐ MRI
- ☐ CT
- ☐ EMG

Previous Injections
- ☒ None
- ☐ Did not help
- ☐ Helped temporarily
- ☐ Helped a little
- ☐ Helped significantly

Previous Physical Therapy
- ☒ None
- ☐ Did not help
- ☐ Helped temporarily
- ☐ Helped a little
- ☐ Helped significantly

PT Name and Tel. Number:

Currently Working?
- ☐ No
- ☒ Yes; Employer & Job Title: Iron Workers Union 365

Accident related to MVA/Work?
- ☐ MVA
  Date of Accident:
- ☐ Work
  Date of accident:

Can you undergo an MRI?
- ☒ Yes
- ☐ No, Reason:

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Name: Brian SIDOTE

Social and Medical History

Primary Care Provider: N/A **Referring Provider:** N/A

Are you currently under medical treatment? ☐ Yes ☒ No

Have you ever had any previous surgeries ? ☐ Yes ☒ No

If so, please describe _____

Are you currently taking any medications? ☒ Yes ☐ No

If so, please list Oxycodone and Advil

Do you smoke? ☒ Never ☐ Former Smoker ☐ Current Smoke

Do you drink alcohol? ☐ Never ☒ Occasional ☐ Frequent

Do you use glasses/contact? ☐ Yes ☒ No

Do you have a pacemaker? ☐ Yes ☒ No

Are you or your family diagnosed with any of the following: ☐ **No to all**

AIDS/HIV	☐ Yes	☒ No	☐ Family	Hepatitis	☐ Yes	☒ No	☐ Family
Anemia	☐ Yes	☒ No	☐ Family	High Cholesterol	☐ Yes	☒ No	☐ Family
Any Issues with Anesthesia	☐ Yes	☒ No	☐ Family	Hypertension	☐ Yes	☒ No	☐ Family
Arthritis	☐ Yes	☒ No	☐ Family	Kidney Disease	☐ Yes	☒ No	☐ Family
Asthma	☐ Yes	☒ No	☐ Family	Liver Disease	☐ Yes	☒ No	☐ Family
Bleeding Disorders	☐ Yes	☒ No	☐ Family	Orthotics	☐ Yes	☒ No	☐ Family
Blood Clots	☐ Yes	☒ No	☐ Family	Osteoporosis	☐ Yes	☒ No	☐ Family
Blood Transfusion	☐ Yes	☐ No	☐ Family	Rheumatoid Arthritis	☐ Yes	☒ No	☐ Family
COPD	☐ Yes	☒ No	☐ Family	Seizures	☐ Yes	☒ No	☐ Family
Cancer	☐ Yes	☒ No	☐ Family	Stroke	☐ Yes	☒ No	☐ Family
Coronary Artery Disease	☐ Yes	☒ No	☐ Family	Thyroid Problems	☐ Yes	☒ No	☐ Family
Heart Attack	☒ Yes	☐ No	☒ Family	Tuberculosis	☐ Yes	☒ No	☐ Family
Heart Problems	☒ Yes	☐ No	☒ Family	Ulcers	☐ Yes	☒ No	☐ Family

Review Of Systems ☒ **No to all**

Constitutional
- Fever ☐ Yes ☐ No
- Night Sweats ☐ Yes ☐ No
- Weight Gain ☐ Yes ☐ No
- Weight Loss ☐ Yes ☐ No
- Chills ☐ Yes ☐ No

Eyes
- Dry Eyes ☐ Yes ☐ No
- Vision Change ☐ Yes ☐ No
- Eye Disease/Injury ☐ Yes ☐ No

ENMT
- Difficulty Hearing ☐ Yes ☐ No
- Ear Pain/Ringing ☐ Yes ☐ No
- Nose Bleeds ☐ Yes ☐ No
- Nose/Sinus Issues ☐ Yes ☐ No
- Sore Throat ☐ Yes ☐ No
- Snoring ☐ Yes ☐ No
- Oral Abnormalities ☐ Yes ☐ No

Cardiovascular
- Chest Pain ☐ Yes ☐ No
- Palpitations ☐ Yes ☐ No
- Heart murmur ☐ Yes ☐ No

Respiratory
- Cough ☐ Yes ☐ No
- Shortness of breath ☐ Yes ☐ No
- Sleep Apnea ☐ Yes ☐ No

Gastrointestinal
- Abdominal Pain ☐ Yes ☐ No
- Nausea/Vomiting ☐ Yes ☐ No
- Consti[ation ☐ Yes ☐ No
- GERD ☐ Yes ☐ No

Skin
- Rashes ☐ Yes ☐ No
- Psoriasis ☐ Yes ☐ No
- Growths ☐ Yes ☐ No

Neurological
- Weakness ☐ Yes ☐ No
- Numbness ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No
- Headaches ☐ Yes ☐ No

Psychiatric
- Depression ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Memory Loss ☐ Yes ☐ No

Endocrine
- Fatigue ☐ Yes ☐ No

Hematologic/Lymphatic
- Swollen Glands ☐ Yes ☐ No
- Easy Bruising ☐ Yes ☐ No

Allergic/Immunologic
- Runny Nose ☐ Yes ☐ No
- Sinus Pressure ☐ Yes ☐ No
- Itching/Hives ☐ Yes ☐ No

By signing below, I am confirming that all the above information is true and correct.

Patient Signature DocuSigned by: Brian Sidote D2B0366F3F148E... Date 5/28/2021

COMPLETE ORTHOPEDICS
www.cortho.org
631-981-2663

HIPAA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize AA Medical P.C. my treating physicians and their respective designees; including a third party medical records company, to use and disclose by health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for all purposes necessary for treatment, payment and healthcare operations, including but not limited to release of information requested by my insurance company (or carrier), any information necessary for planning purposes, as well as authority to leave messages, texts, or faxes on all numbers and emails that I have provided to the office.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to the office. However, this authorization may not be revoked if its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

RELEASE OF BILLING INFORMATION

I agree and provide consent for the provider and its staff to do the following on my behalf; (1) File Patient Medical Claims with my Health Plan; and (2) file any necessary appeals of denied or partially paid Patient Medical Claims with my Plan or regulatory authorities on my behalf; and (3) file any necessary external appeals with regulatory authorities; and (4) to obtain a complete copy of my Health Plan, Health Policy, Summary of Declaration of Benefits, and Plan Description; and (5) to obtain any medical records or reports of the Patient including HIV and psychological records needed to obtain reimbursement of the Patient's Medical Claims.

ASSIGNMENT OF BENEFITS

I agree and provide consent for the provider and its staff to do the following on my behalf; (1) File Patient Medical Claims with my Health Plan; and (2) file any necessary appeals of denied or partially paid Patient Medical Claims with my Plan or regulatory authorities on my behalf; and (3) file any necessary external appeals with regulatory authorities; and (4) to obtain a complete copy of my Health Plan, Health Policy, Summary of Declaration of Benefits, and Plan Description; and (5) to obtain any medical records or reports of the Patient including HIV and psychological records needed to obtain reimbursement of the Patient's Medical Claims

DocuSigned by:
Brian Sidote

Signature of Patient or Personal Representative

Brian SIDOTE

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

5/28/2021

Date

COMPLETE ORTHOPEDICS
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OFFICE POLICIES AND PROCEDURES

1. RELEASE OF INFORMATION: I authorize AA MEDICAL, PC, my treating physicians and their respective designees, to use and disclose my health information for all purposes necessary for treatment, payment and healthcare operations, including but not limited to release of information requested by my insurance company (or carrier), any information necessary for planning purposes, as well as authority to leave messages, texts, or faxes on all numbers and emails that I have provided to their office.

2. ASSIGNMENT OF INSURANCE: I hereby authorize my insurance benefits to be paid directly to AA MEDICAL, PC. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

3. FINANCIAL LIABILITY: I hereby agree to pay all charges due (or become due) to AA MEDICAL PC for care and treatment, including copayments and deductibles as provided under my plan. Benefits, if any, paid by a third party will be credited on account. I understand that I will be responsible for any charges if any of the following apply:
- My health plan requires pre authorization or referral by a Primary Care Physician before receiving services at AA MEDICAL PC and I have failed to obtain such an authorization or referral or I receive services in excess of such authorization or referral, and/or.
- My health plan determines that the services I receive at AA MEDICAL PC are not medically necessary and/or not covered by my insurance plan.
- My health plan coverage has lapsed and/or expired at the time I receive services at AA MEDICAL PC. I have chosen not to use my health plan coverage.

4. CANCELLED OR NO-SHOW APPOINTMENTS: I understand that I may incur a cancellation fee of $50 if I do not provide 24 hour notice of cancellation, or if I do not show to my appointment without calling to cancel.

5. PHONE CONSULTATIONS: If for any reason I require a phone consultation with the physician or medical staff, I am aware that there will be a charge to me as determined by the practice.

6. COLLECTIONS: If I should become delinquent on my account and sent to collections I will be responsible for all reasonable attorney fees and costs, as well as the practice fee for being sent to collections.
- I agree that reasonable attorney fees shall be equal to the greater of ⅓ of the amount outstanding or $750 per hour.
- I agree that any action to recover unpaid charges shall be venued in Suffolk County, NY.

7. PAYMENT: If I can not pay at the time of service I am aware that there is a 50 dollar processing fee in addition to my bill.

8. AUDIO-VISUAL SURVEILLANCE : I am aware that the office is under visual and audio surveillance. I am aware that I may be recorded in common areas and consent to being so.

DocuSigned by: Brian Sidote

Signature of Patient or Personal Representative

Brian SIDOTE

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

5/28/2021

Date

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Financial Policy and Notice of Privacy Act

We now use a Credit Card Merchant Service which gives us the ability to swipe your credit card, debit card, or health savings account card to accept payment in the office and have the number securely stored on a remote server with Instamed. The full credit card number is NOT visible to us and is NOT stored in our office.
We want to assure you that our software has been thoroughly vetted according to the strict data retention rules required by the merchant processing system. The only information stored at our office in our secure, encrypted system, is the name on the card, the expiration date, and the last 4 digits of the card number.
We require your credit card information to be stored for future payment for some of the following reasons:

- Policy has terminated, or there is a gap in coverage.
- You may have a copayment for medical services.
- You wish to set up a payment plan for a large balance on account.
- You have missed your appointment and did not advise staff

Our office will send you a receipt of any charges that are made to your card.

AUTHORIZATION

By signing below, I authorize AA Medical to keep a credit card on file for future payments on the patients listed below with the information saved. I am aware that if any of my personal information has changed, I am responsible to notify AA Medical of the change(s) to ensure they have the most current information to contact me or process payment accurately.
By signing below, I confirm I have reviewed and understand AA Medical's Financial Policy and Notice of Privacy Act

DocuSigned by: Brian Sidote
Signature of Patient or Personal Representative

Brian SIDOTE
Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

5/28/2021
Date

Consent for Treatment During COVID-19 Pandemic

I, Brian SIDOTE, knowingly and willingly consent to have orthopedic treatment, including but not limited to physical examinations and injections/aspiritations, completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny nose
- Sore throat

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days with anyone they may be around, which is not possible with healthcare.

- I verify I have not traveled outside of the United States in the past 14 days to countries that have been affected by COVID-19.
- I verify that I have not traveled domestically within the United Stated by commercial airlines, bus, or train within the past 14 days.

Patient Signature DocuSigned by: Brian Sidote Date 5/28/2021

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I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to the office. However, this authorization may not be revoked if its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

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I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

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Signature of Patient or Personal Representative	Print Name of Patient or Personal Representative
	5/28/2021
Description of Personal Representative's Authority	Date

I hereby assign and convey all benefit and non-benefit rights (including the rights to all payments) under my health insurance policy or benefit plan to AA Medical, P.C. with respect to all medical services provided by AA Medical, P.C. and its surgeons or providers for all dates of service. It is specifically intended by this assignment of benefits to assign all of my rights to bring any appeal, lawsuit or administrative proceeding for and on my behalf, in my name against any person or entity involved in the determination of benefits under my insurance policy of benefit plan, including any fiduciary claim.

I hereby appoint as my Designated Authorized Representative AA Medical, P.C. under ERISA and its governing regulations and rulemaking, to communicate with my insurers, plan fiduciaries, employers, and claims administrators related to my plan benefits and internal appellate rights.

AA Medical, P.C. is hereby authorized and directed to provide and release by Protected Health Information ("PHI") for purposes of exercising the rights and benefits set forth in this Assignment and Designated Authorized Representative to any "Covered Person" (included payors or other entities that may assist in reimbursement). I direct the plan, plan sponsor, and claims administrator to share all PHI with my provider and Authorized Representative.

I understand and agree that this Assignment and Designation of Authorized Representative shall remain in full force and effect for all current and future dates of service until such time as I may revoke this authority upon written notice.

Brian Sidote	Brian SIDOTE
Signature of Patient or Personal Representative	Print Name of Patient or Personal Representative
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- I verify that I have not traveled domestically within the United Stated by commercial airlines, bus, or train within the past 14 days.

Patient Signature _____ Date 5/28/2021

CORRESPONDENCE - BILLING for SIDOTE, BRIAN 04/16/1987 (37yo M) #21992

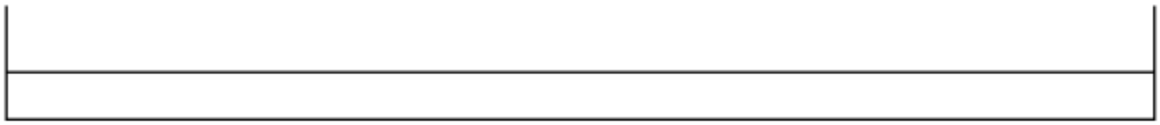
AA MEDICAL
2500 NESCONSET HWY
BUILDING 10 UNIT D
STONY BROOK, NY 11790

Date: 12/15/2021

ATTENTION: IRON WORKERS CLAIM DEPARTMENT

PATIENT: BRIAN SIDOTE	**DOB: 04/16/1987**
ID NUMBER : MID0024054	
CLAIM # 1993382	**DOS: 06/16/2021**
PROVIDER: VEDANT VAKSHA, MD	
TAX ID NUMBER: 462667021	
OUR RECORDS INDICATE THAT THE ABOVE CLAIM HAS BEEN UNDERPAID. WE REQUEST THAT THE CLAIM BE SENT BACK FOR REVIEW. IN ADDITION WE HEREBY MAKE A FORMAL REQUEST FOR THE CERTIFICATE OR SUMMARY PLAN DESCRIPTION (SPD) APPLICABLE TO THE HEALTHCARE PLAN GOVERNING THIS CLAIM. YOU ARE REQUIRED TO MAKE THIS DOCUMENT AVAILABLE TO US.	

THANK YOU,
DONNA AIELLO, BILLING ADMINISTRATOR
EMAIL: BILLING@CORTHO.ORG
(631)237-3913
FAX #(212)203-9223



MAGNACARE UNION WELFARE LOCAL 202868
PO BOX 1001

GARDEN CITY, NY 115308001

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

XXX PICA — PICA XXX

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MID0024054

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SIDOTE BRIAN

3. PATIENT'S BIRTH DATE: 04 16 1987 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SIDOTE BRIAN

5. PATIENT'S ADDRESS (No., Street): 201 HIGBIE LN

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 201 HIGBIE LN

CITY: WEST ISLIP — STATE: NY

8. RESERVED FOR NUCC USE

CITY: WEST ISLIP — STATE: NY

ZIP CODE: 117952809 — TELEPHONE (Include Area Code): (631) 7861732

ZIP CODE: 117952809 — TELEPHONE (Include Area Code): (631) 7861732

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 04 16 1987 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MAGNACARE UNION WELFARE LOCAL

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE — DATE: 07 29 2021

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 06 16 2021 QUAL.: 431

15. OTHER DATE QUAL.:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE:

17a.:

17b. NPI:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M25562 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 16 21	06 16 21	22		29883	59 LT	A	99756	32 1		NPI	1760762033
2 06 16 21	06 16 21	22		29879	LT	A	58682	32 1		NPI	1760762033
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 462667021 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 7445V21645

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 158438 64

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use: 158438 64

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
VEDANT VAKSHA, MD
SIGNED 07 29 2021 DATE

32. SERVICE FACILITY LOCATION INFORMATION
AA MEDICAL P.C.
50 NY 25 A
SMITHTOWN NY 117873448
a. 1982663423 b.

33. BILLING PROVIDER INFO & PH # ( )
AA MEDICAL, P.C.
PO BOX 27140
BELFAST ME 049152023
a. 1093150385 b.

AA-000012

NUCC Instruction Manual available at: www.nucc.org — *PLEASE PRINT OR TYPE* — APPROVED OMB-0938-1197 FORM 1500 (02-12)

DOCUMENT 7445

Clinical Documents

St. Catherine of Siena Medical Center
Catholic Health Services
At the heart of health

ST CATHERINE OF SIENA
SMITHTOWN, NEW YORK

REPORT OF OPERATION

E1813629
BRIAN SIDOTE
3034455730

PT TYPE:

LOCATION: SGS

PATIENT'S NAME: Sidote, Brian

DATE OF PROCEDURE: 06/16/2021

DATE OF BIRTH: 04/16/1987

SURGEON: Vedant Vaksha, MD

ASSISTANTS:
1. Patrick Greger, PA
2. Brian James, PA

PREOPERATIVE DIAGNOSES:
1. Left knee ACL tear.
2. Left knee medial meniscus, posterior horn tear.
3. Left knee lateral meniscus tear, bucket handle.

POSTOPERATIVE DIAGNOSES:
1. Left knee medial meniscus root tear.
2. Left knee bucket handle lateral meniscus tear with the left knee ACL tear.

OPERATIONS:
1. Left knee medial meniscus root repair.
2. Left knee lateral meniscus repair.
3. Left knee microfracture chondroplasty.

COMPLICATIONS: None.

SPECIMENS: Shavings.

TOURNIQUET TIME: 127 minutes.

BLOOD LOSS: 50 cc.

INDICATION FOR PROCEDURE: The patient is a 34-year-old male who came to my office following injury to the left knee in a kickball game. He came in with a swollen knee. I aspirated the knee and drained blood from the knee. The patient was sent for MRI, which showed the above-mentioned findings. We discussed treatment options and the patient

BRIAN SIDOTE
E1813629
3034455730

opted for surgical management. We discussed possibility of need for repair versus resection of the medial and lateral meniscus and possibility of repair versus reconstruction of ACL tear found one. We also discussed the possibility of staging the procedure if the meniscus repair was prolonged. We also discussed risks and benefits including infection, bleeding, Injury to adjacent nerves and vessels, rehabilitation, need for repeat surgery, failure, staging procedure, knee stiffness, and need for manipulation, need for rehabilitation, systemic complications including blood clot, cardiac or pulmonary, neurological complications including death. The patient understood and signed an informed consent.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room where general anesthesia was induced. The left lower extremity was prepped and draped aseptically in usual fashion. Preop antibiotic was given. A gram of tranexamic acid was also given. Timeout was called. Tourniquet was elevated after exsanguination.

Lateral entry portal was made for the arthroscope. Arthroscope was entered. There was hemarthrosis, this was drained. Medial entry portal was made with use of spinal needle. Examination of the medial tibiofemoral compartment showed tear of the posterior horn meniscus, which was freed. The portion of the meniscus was resected. Further examination showed that the root was avulsed and tagged by only the capsular attachment.

Decision was done to root repair. Examination of the intercondylar notch showed tear of the ACL with synovial reaction. Examination of the lateral tibiofemoral compartment showed a bucket handle tear, which was into the intercondylar notch. There was also a flap along the posterior horn of the medial meniscus in a form of a tongue. The decision was done to repair the meniscus. Posterolateral incision was given along the posterolateral corner of the knee. With sharp and blunt dissection along the posterior margin of the LCL, the knee capsule was reached. A space was generated between the gastrocnemius and the knee capsule. A speculum was inserted to avoid injury to the neurovascular bundle posterior to the knees.

Now, the repair of lateral meniscus was planned. Combination of FastFixes as well as Ti-Cron needle sutures should pass through _____ specific cannulas were done. The repair also involved tying down the tongue fragment along with the bucket handle fragment. The meniscal soft tissues were prepared before the repair with the use of shaver and rasp. All the three Ti-Cron needles could have been passed along with the use of six FastFixes for all Inside repair. The Ti-Cron needle was delivered out of the posterolateral wound. Pictures were taken and saved.

Now, the scope was entered into the medial portal to complete the repair of the lateral meniscus. The repair of the medial root was performed through the medial portal and the scope in the lateral portal.

CORRESPONDENCE - BILLING for SIDOTE, BRIAN 04/16/1987 (37yo M) #21992

zelis

The attached proposal is being submitted to you for consideration and remittance of payment on the below detailed claim in accordance with the terms and conditions contained herein.

Details	Patient ID:	73743380	Contact:	Donna xt 1053
	Patient Name:	SIDOTE, BRIAN	Phone:	6319812663
	Date(s) of Service:	06/16/21 - 06/16/21	Fax:	212-203-9223
	Payor:	Iron Workers Locals 40, 361 and 417 Health Fund		
	Claim ID:	1993382		
	Provider:	AA MEDICAL PC		
	Total Billed Amount:	$158,438.64		
	Repriced Amount:	$797.75		

Terms

This Agreement outlines Provider's willingness to accept the following terms on the above claim:

1. The Repriced Amount will be agreed to on this claim.
2. Any interest or penalties relating to the claims processed by the Payor will be waived by Provider.
3. In consideration, Provider will receive payment within 15-20 working days from the date this document is received in the Zelis office. The EOB/EOP remark will designate that the discount is through Zelis or PHX.
4. Payment from the Payor will be subject to any benefit plan terms such as deductibles, co-insurance, co-pays, exclusions and code edit reductions per the plan guidelines. Provider agrees not to balance bill the Payor, administrator and/or patient for the difference between the Total Billed Amount and the Repriced Amount in accordance with the terms of this Agreement.

Acceptance

I have the authority to accept the provisions outlined in this Agreement and further provide the payor the assurance the proceeds associated with this claim have not been previously assigned to any other organization.

Please sign below and fax to (973) 587-2102 or call us at (908) 389-8400.

Signature _____ Date _____

Printed Name _____ E-Mail Address _____

If you have any questions, please contact me at (908) 389-8400.

Sincerely,

Samantha Gries

Samantha Gries
Claims Associate

**Zelis Claims Integrity LLC is not financially responsible and/or liable for any payments to the Provider. Payment of benefits, if any, is subject to the terms and conditions of the Payor's plan design and/or existing contracts. This agreement does not constitute, nor should it be construed as, a guaranty of payment by the Payor.*

Zelis Claim ID: 203652209

zelis

The attached proposal is being submitted to you for consideration and remittance of payment on the below detailed claim in accordance with the terms and conditions contained herein.

Details	Patient ID:	73743380	Contact:	Donna xt 1053
	Patient Name:	SIDOTE, BRIAN	Phone:	6319812663
	Date(s) of Service:	07/15/21 - 07/15/21	Fax:	212-203-9223
	Payor:	Iron Workers Locals 40, 361 and 417 Health Fund		
	Claim ID:	1993383		
	Provider:	AA MEDICAL PC		
	Total Billed Amount:	$96,549.87		
	Repriced Amount:	$651.97		

Terms

This Agreement outlines Provider's willingness to accept the following terms on the above claim:

1. The Repriced Amount will be agreed to on this claim.
2. Any interest or penalties relating to the claims processed by the Payor will be waived by Provider.
3. In consideration, Provider will receive payment within 15-20 working days from the date this document is received in the Zelis office. The EOB/EOP remark will designate that the discount is through Zelis or PHX.
4. Payment from the Payor will be subject to any benefit plan terms such as deductibles, co-insurance, co-pays, exclusions and code edit reductions per the plan guidelines. Provider agrees not to balance bill the Payor, administrator and/or patient for the difference between the Total Billed Amount and the Repriced Amount in accordance with the terms of this Agreement.

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Signature _____ Date _____

Printed Name _____ E-Mail Address _____

If you have any questions, please contact me at (908) 389-8400.

Sincerely,

Samantha Gries

Samantha Gries
Claims Associate

**Zelis Claims Integrity LLC is not financially responsible and/or liable for any payments to the Provider. Payment of benefits, if any, is subject to the terms and conditions of the Payor's plan design and/or existing contracts. This agreement does not constitute, nor should it be construed as, a guaranty of payment by the Payor.*

Zelis Claim ID: 203652210

CORRESPONDENCE - BILLING for SIDOTE, BRIAN 04/16/1987 (37yo M) #21992

AA MEDICAL
2500 NESCONSET HWY
BUILDING 10 UNIT D
STONY BROOK, NY 11790

Date: 09/28/2021

ATTENTION: APPEAL DEPARTMENT FAX 845-336-7989

PATIENT : BRAIN SIDOTE
ID # MID0024054
TAX ID NUMBER: 462667021
OUR RECORDS INDICATE THAT CLAIMS FOR THE ABOVE ID NUMBER AND TAX ID NUMBER WERE UNDERPAID. WE ARE REQUESTING THAT YOU SEND THE PLAN DOCUMENTS FOR THIS PATIENT. PLEASE CONSIDER AS AN APPEAL FOR ALL CLAIMS ON THIS PATIENT.
PLEASE CONTACT ME IF YOU HAVE ANY FURTHER QUESTIONS
THANK YOU,
DONNA AIELLO, BILLING ADMINISTRATOR
EMAIL: BILLING@CORTHO.ORG
(631)237-3913
FAX #(212)203-9223

Dear Appeals/Plan Administrator[1],

We are counsel to AA medical PC (tax ID 462667021), the assignee and designated authorized representative of the patient[2] and are filing this First Level Member Appeal on their behalf. Attached are the requisite authorization, assignment and HIPAA forms. All further communications regarding this claim should be directed to our attention as authorized legal counsel.

PLEASE SEE ATTACHED CLINICALS AND EOBS WITH CPTS AND BILLED AND PAID AMOUNTS ALONG WITH CLAIM NUMBER

Patient is a member of, beneficiary of, participant in, and/or insured by a health insurance policy or benefit plan (the "Plan") issued and/or administered by ("Insurance Company") and/or sponsored by ("Employer").

Please note the Provider's superior education, experience and skills.

A total billed charge was billed by our client as their reasonable and customary fee for these services and the Plan reimbursed less than the billed charges. Payment of the billed charges was not made in accordance with the Plan.

In addition to the items listed on Exhibits A and B, this appeal challenges the issues below in the administration of this claim.

We hereby request from the Plan Administrator copies of all of the documents listed on Exhibit B to this appeal. Documents should be sent to the undersigned at the address set forth on this letter. Please also advise if the Plan maintains an anti-assignment clause prohibiting a member from assigning its benefits and rights under the Plan to a third party.[3] Notwithstanding an anti-assignment clause, we maintain our right to act as a limited power of attorney in this instance.

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[1] This appeal is filed with the Plan Administrator of the above captioned plan, or appropriate named fiduciary or insurer of the plan. Any individual who is not designated as plan administrator or appropriate named fiduciary by this plan is required, by ERISA and as your fiduciary duty, to forward this appeal document to such appropriate individual.

[2] Case law states that an assignee of a valid ERISA assignment (as is the case here) obligates the insurance company to make all reimbursement payments directly to the provider. See, Robert Metcalf v. Blue Cross Blue Shield of Michigan et al., 57 F. Supp. 3d 1281 (D. Or. 2013). (Insurance company must pay an out-of-network provider with a valid complete ERISA assignment, even after his patients were already paid. Any additional payments made to patient will not extinguish insurance companies' obligation to pay the provider under ERISA when provider holds a valid complete ERISA assignment).

[3]See American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield, 890 F.3d 445 (3d Cir. 2018)(court left open the right of providers under an ERISA plan to challenge payment through a 'power of attorney' granted by the patient to the provider.)

Additional payment is required for this claim so that benefits are paid in accordance with the Plan. A response to this First Level Member Appeal is required within 30 days of the date hereof as provided under ERISA. The response must address each and every argument raised herein in order to comply with the requirements of ERISA.

If you have any questions, do not hesitate to contact me.

Sincerely,

Donna Aiello

Billing Administrator, AA Medical PC

Phone: 631-237-3913

Fax: 212-203-9223
Email: billing@cortho.org

2500 Nesconset Highway, Building 10 Unit D
Stony Brook, NY 11790

w/ enc.

Aaron A. Mitchell, Esq.
Partner
Lawall & Mitchell, LLC
p: 973-285-3280
c: 914-760-8963
w:lmesq.com
e: aaron@lmesq.com

EXHIBIT A

The administration of this claim has been undertaken in violation of ERISA as follows:

1. The notice of adverse benefit determination failed to comply with the requirements of ERISA. 29 C.F.R. § 2560.503–1(g)
2. This claim was not processed on a timely basis as required by ERISA and under the Plan. 29 C.F.R. § 2560.503-1(f)
3. The Claims Administrator engaged in procedural irregularities for the purpose of hindering and/or delaying the processing of this claim. Abatie v. Alta Health & Life Ins. Co., 458 F. 3d 955 (9th Cir. 2006)
4. The Claims Administrator under the Plan has several conflicts of interest and has placed its own financial interest ahead of the Patient. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 117 (2008)
5. The Insurance Company purposely narrows its network of providers in an effort to shift costs to plan participants in violation of ERISA.
6. The administration of this claim has discriminated against the Patient in violation of Federal and State law.
7. The administration of the claim violated applicable State statutory and common law.
8. The administration of this claim did not meet the reasonable expectations of the Patient.
9. Out-of-network benefits under the Plan are illusory. Interline Brands, Inc. v. Chartis Specialty Ins. Co., 749 F.3d 962, 966–67 (11th Cir. 2014); Point of Rocks Ranch, LLC v. Sun Valley Title Ins. Co., 143 Idaho 411, 146 P.3d 677, 680 (2006)
10. Fiduciaries under the Plan did not administer the Plan solely for the benefit of Patient.
11. Fiduciaries of the Plan misrepresented the benefits available under the Plan and did not disclose in reasonably clear language, understood by the ordinary person, the limitations of benefits under the Plan. 29 CFR 2520.102-2(a); Moench v. Robertson, 62 F. 3d. 553, 566 (3d Cir. 1995)
12. Plan Sponsor and/or Plan Administrator violated their fiduciary duties of loyalty and prudence in the selection and ongoing monitoring of Insurance Company. Tibble v. Edison Int'l, 135 S. Ct. 1823, 1826 (2015); DOL Information Letter to D. Ceresi, 1998 WL 1638068 (Feb. 19, 1998)

EXHIBIT B

1. Identification of the Plan Administrator and Plan Sponsor of this employee benefit health plan, including name, address, email address and telephone number.
2. Identification of the Claims Administrator of this employee benefit health plan, including name, address, email address and telephone number.
3. A complete copy of the controlling Plan Documents including all amendments, Summary Plan Description(s) (SPD) or Certificate of Insurance.
4. The latest annual report (Form 5500), bargaining agreement, trust agreement, contract or other instruments under which the plan is established and operated.
5. A complete copy of any past and current contracts between this employee benefit plan and the third party administrator (TPA), under which the plan is established or operated, in accordance with DOL Advisory Opinion 97-11A.
6. The specific plan provisions on which the denial was based.
7. The appeal (claims review) procedures established and maintained for this plan as required by ERISA.
8. Any and all internal rules, guidelines, protocols or other similar criterion relied upon in making the adverse benefit determination.
9. Any document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan. Accordingly, studies, schedules or similar documents that contain information and data, such as information and data relating to standard charges for specific medical or surgical procedures, that, in turn, serve as the basis for determining or calculating a participant's or beneficiary's benefit entitlements under an employee benefit plan would constitute "instruments under which the plan is operated including the schedule of “usual and customary” fees or “allowable amounts”.
10. An explanation of the scientific or clinical judgment for the determination regarding medical necessity or experimental treatment and any scientific information relied on.
11. Identification and professional qualifications as well as credentials of individual(s) who performed clinical claims determinations.
12. Identification and professional qualifications as well as credentials of individual(s) who performed billing and claims determinations.
13. Any and all internal memos and telephone communication logs associated with this claim denial and appeal, including any in-house and outside counsel’s advice and opinions rendered on record in connection with handling this claim denial and review.
14. Identification of the forum that has been designated in the Plan for post-appeal disputes/litigation (e.g., American Arbitration Association, Federal Court, State Court).

Iron Workers Locals 40, 361 & 417 Health Fund
451 Park Ave South, New York, NY 10016

Payee: AA MEDICAL PC
Payee Tax ID # 46-2667021 Check Amount: $3,473.22

Insured: BRIAN SIDOTE **Relationship:** SELF **Plan:** Indemnity Plan
Patient: BRIAN SIDOTE **Paid To:** Provider **Claim #:** 1993382 **Check#:** 1750416
Provider: VEDANT VAKSHA **Patient Account:** 7445V21645 **Check Date:** 10/19/2021

Date(s) of Service		Proc	Qty	Billed	Cons	Inelig	Co Pay	Ded	Co Ins	Paid	Cmt
06/16/21	06/16/21	2988359 Knee Arthroscopy/Surg	1.00	99,756.32	5,668.09	0.00	0.00	195.00	1,999.87	3,473.22	
06/16/21	06/16/21	29879LT Knee Arthroscopy/Surg	1.00	58,682.32	0.00	58,682.32	0.00	0.00	0.00	0.00	CONSD

The operative report does not describe any lesion in the knee that would require a microfracture chondroplasty. Furthermore, the MRI study from 06/02/21 did not identify an articular cartilage lesion in the left knee. Therefore, the supplied records do not support performing a microfracture chondroplasty of the left knee.

Claim Totals:	**158,438.64**	**5,668.09**	**58,682.32**	**0.00**	**195.00**	**1,999.87**	**3,473.22**

Cmt Code : CONSD - Procedure denied as per Medical Consultant review.;

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110321-2-9934-1935